#0577 P.002/008

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/12/2009 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R WING 06/03/2009 475037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 378 PROSPECT STREET **ROWAN COURT HEALTH & REHAB BARRE, VT 05641** PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IĎ (X4) ID PREFIX PREFIX TAG TAG DEFICIENCY) F 000 F 000 INITIAL COMMENTS An unannounced onsite complaint investigation was completed by the Division of Licensing and Protection on 6/3/09. F 151 483.10(a)(1)&(2) EXERCISE OF RIGHTS F 151 Tag F 151 SS=D The resident has the right to exercise his or her rights as a resider t of the facility and as a citizen Residents # 1 did not have any adverse or resident of the United States. affects from this alleged deficient practice. Residents # 1 did receive all The resident has the right to be free of three meals as required. interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. All residents who present with unacceptable behaviors have the potential to be affected. This REQUIREMENT is not met as evidenced by: All nursing staff will be in-serviced on the Based on observation, interview, and record review, the facility failed to assure 1 applicable proper way to deal with unacceptable resident is allowed to exercise his or her rights as behaviors. a resident of the facility (Resident #1). Findings include: Proper practices will be monitored through random audits of Nurse's Notes with all Per record review, Resident #1 was not allowed residents presenting with unacceptable to make choices about where he/she ate meals. behaviors for 60 days. Said audits to be Per the most recent MDS (Minimum Data Set) completed once a week at a minimum. with an Assessmeht Reference Date of 5/5/09, Resident #1 was coded as having no problems with short or long term memory, and is Results of the audits will be reported to the independent with decision making. Per a nurses' **Quality Improvement Committee monthly** note dated 4/27/09, after an incident of by the Director of Nurses or designee. inappropriate behavior in the main dining room involving Resident #1, "Admin. stated no meals in DR (dining room) as it was a privilege and he had The Director of Nurses or designee will be abused his options. To be out of DR until further responsible for compliance. notice." This behavior modification strategy was not added to the plan of care, and the resident The corrective action plan completion date: 6/29/2009 was not allowed to eat with his/her peers until 5/27/09. On 5/28/09 an incident occurred P.O.C. Accepted 424109 involving objects falling to the floor in Resident mulamonaliN

LABORATORY DIRECTOR'S OR PROVIDER'S UPPLIED REPRESENTATIVE'S SIGNATURE

ministrator

(X6) DAI

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other saleguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

#0677 P. 003/008 PRINTED: 06/12/2009 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 06/03/2009		
		475037					
NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH &		STREET ADDRESS, CITY, STATE, ZIP CODE  378 PROSPECT STREET  BARRE, VT 05641					
(X4) ID PREFIX TAG	JEACH DESICIENT	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE	
F 151	"Since then has be all meals." Per ob all meals." Per ob 6/3/09, a nurse to Administrator] too away because of in your room" It 2:00 PM, the resign out and eat with he was "definitely was an accident." survey, Resident room.	age 1 es' note, dated 5/28/09, states een told he must eat in his room servation, at 10:03 AM on d Resident #1 that "[The k your dining room privileges the incident with making a mess uring an interview on 6/3/09 at lent stated that he "would like to h the other people" and stated punished for something that Per observation on the day of #1 ate the noon meal in his/her	F 151				
F 203 SS=0	Before a facility to resident, the facility to resident, the facility to resident, a family of the reasons for the reasons for the reasons in the include in the no paragraph (a)(6)	ansfers or discharges a ity must notify the resident and, member or legal representative the transfer or discharge and re move in writing and in a anner they understand; record resident's clinical record; and ice the items described in	F 203				
	this section, the required under p must be made b before the reside Notice may be n before transfer c individuals in the under (a)(2)(iv)	notice of transfer or discharge aragraph (a)(4) of this section the facility at least 30 days and as soon as practicable of discharge when the health of a facility would be endangered of this section; the resident's sufficiently to allow a more					

#0677 P.004/008

PRINTED: 06/12/2009 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 06/03/2009 475037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 378 PROSPECT STREET **ROWAN COURT HEALTH & REHAB BARRE, VT 05641** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG DEFICIENCY) TAG F 203 Continued From page 2 F 203 immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this Tag F 203 section; or a resident has not resided in the facility for 30 days Resident # 1 did not have any adverse effects from this alleged deficient practice. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer All residents who receive a notice of involuntary or discharge; the effective date of transfer or discharge; the location to which the resident is discharge has the potential to be affected. transferred or discharged; a statement that the resident has the right to appeal the action to the All administrative personnel will be in-serviced on the State; the name, address and telephone number Importance of making sure any involuntary discharge of the State long term care ombudsman; for nursing facility residents with developmental receives a 30 day notice in a timely basis. disabilities, the mailing address and telephone number of the agency responsible for the Proper practices will be monitored with any protection and advocacy of developmentally further case discussed in morning meeting. disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill Any involuntary discharges will be reported of Rights Act, and for nursing facility residents who are mentally lill, the mailing address and to the Quality improvement Committee telephone number of the agency responsible for monthly for the next 3 months by the the protection and advocacy of mentally ill Director of Nurses or designee. individuals established under the Protection and

This REQUIREMENT is not met as evidenced

Advocacy for Mentally III Individuals Act.

by:
Based on interview and record review, the facility
failed to provide a 30 day written notice of
involuntary discharge for 1 applicable resident
(Resident #1). Findings include:

Per record review and staff interview, a 30 day eviction notice was given verbally to Resident #1 on 5/28/09 by the facility Administrator. The

The Director of Nurses or designee will be responsible for compliance.

The corrective action plan completion date: 6/29/2009

P.O.C. Accepted 6/24/09. Pamelamentarn

#0877 P.005/008

PRINTED: 06/12/2009 FORM, APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 8. WING 06/03/2009 475037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 378 PROSPECT STREET ROWAN COURT HEALTH & REHAB BARRE, VT 05641 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 203 Continued From page 3 F 203 resident was discharged from the facility on 6/4/09. Per interview on 6/3/09 at 11:55 AM, the Administrator confirmed that a written discharge notice was not issued to the resident or legal responsible party. F 242 F 242 483.15(b) SELF-DETERMINATION AND SS=D | PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or Tag F 242 her interests, assessments, and plans of care; interact with members of the community both Resident # 1 did not have any adverse inside and outside the facility; and make choices effects from this alleged deficient practice. about aspects of his or her life in the facility that All residents who present with unacceptable are significant to the resident. behaviors have the potential to be affected. Nursing staff will be in-serviced on the need to follow the care plan as it relates to This REQUIREMENT is not met as evidenced addressing behaviors. Based on interview, observation, and record Yer telephone call E Jamie Jones, DNS 6124/09 12:15pm review, the facility failed to allow 1 applicable resident to make choices about aspects of his or Random audits of care plans weekly forher life in the facility (Resident #1). Findings 68 days: 📣 include: Results of the audits will be reported to the Per record review, Resident #1 was not allowed Quality Improvement Committee monthly to make choices about where he/she ate meals. for the next 3 months by the Director of Per the most recent MDS (Minimum Data Set) with an Assessment Reference Date of 5/5/09,

Nurses or designee.

The Director of Nurses or designee will be responsible for compliance.

The corrective action plan completion date: 06/29/2009 Proper practices will be monitored through random audits of nurses notes with all residents presenting with unacceptable behaviors for 60 days Said audits to be completed once a week at a minimum.

FORM CMS-2567(02-99) Previous Versions Obsolete

Resident #1 was coded as having no problems with short or long term memory, and is

note dated 4/27/09, after an incident of inappropriate behavior in the main dining room

independent with decision making. Per a nurses'

involving Resident #1, "Admin, stated no meals in

DR (dining room) as it was a privilege and he had

abused his options. To be out of DR until further notice." This behavior modification strategy was

not added to the plan of care, and the resident

Event ID: J6EZ11

Facility ID: 475037

If continuation sheet Page 4 of 6

P.O.C. Accepted 6/24/09. RambamostaRN

#0677 P.006/008

PRINTED: 06/12/2009 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 06/03/2009 475037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 378 PROSPECT STREET **ROWAN COURT HEALTH & REHAB BARRE, VT 05641** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAĠ DEFICIENCY) TAG F 242 F 242 Continued From page 4 was not allowed to eat with his/her peers until 5/27/09. On 5/28/09 an incident occurred involving objects falling to the floor in Resident #1's room. A nurses' note, dated 5/28/09, states "Since then has been told he must eat in his room all meals." Per observation, at 10:03 AM on 6/3/09, a nurse told Resident #1 that "[The Administrator took your dining room privileges away because of the incident with making a mess in your room..." During an interview on 6/3/09 at 2:00 PM, the resident stated that he "would like to go out and eat with the other people" and stated he was "definitely punished for something that was an accident. Per observation on the day of survey, Resident #1 ate the noon meal in his/her room. Also see F151. F 280 F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE SS=D | CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or

FORM CMS-2567(02-99) Previous Versions Obsolete

each assessment.

changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after

Event ID: J6EZ11

Facility ID: 475037

If continuation sheet Page 5 of 6

#0677 P.007/008

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/12/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-0391			
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED C 06/03/2009	
		475037			06/0		
ROWAN (	COURT HEALTH & SUMMARY ST	REHAB ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	Y (EACH CORREC	ET  PLAN OF CORRECTION CTIVE ACTION SHOULD BE	(XS) COMPLETION	
PREFIX TAG	REGULATORY OR	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFEREN	NCED TO THE APPROPRIATE DEFICIENCY)	PATE	
F 280	Continued From p	age 5 <sup>.</sup>	F2	80			
	This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to revise the care plan of 1 applicable resident in the targeted sample (Resident #1). Findings include:  Per record review was not revised to include a behavior modification strategy that restricts Resident #1 to his/her room for all meals. Per a nurses' note dated 4/27/09, after an incident of inappropriate behavior in the main dining room involving Resident #1, "Admin. stated no meals in DR (dining room) as it was a privilege and he had abused his options. To be out of DR until further notice." This behavior modification strategy was not added to the plan of care, and the resident was not allowed to eat with his/her peers until 5/27/09. On 5/28/09 an incident occurred involving objects falling to the floor in Resident #1's room. A nurses' note, dated 5/28/09, states "Since then has been told he must eat in his room all meals." Per observation, at 10 03 AM on 6/3/09, a nurse told Resident #1 that "The Administrator] took your dining room privileges away because of the incident with making a mess in your room" Per observation on the day of survey, Resident #1 ate the noon meal in his/her room. At 1:20 PM on 6/3/09, the ADNS confirmed that the care plan did not address the resident having to eat all meals in his/her room.		behaviors have the potential to Nursing staff will be in-service to follow the care plan as it reseaddressing behaviors.  Random audits of care plans via 60 days.  Results of the audits will be resultly improvement Commit for the next 3 months by the Inverse or designee.  The Director of Nurses or designee.		this alleged deficient practice. who present with unacceptable to the potential to be affected will be in-serviced on the need care plan as it relates to ehaviors.  Its of care plans weekly for the audits will be reported to the overment Committee monthly a months by the Director of signee.  Of Nurses or designee will be for compliance.	cient practice. In unacceptable Ito be affected. Ito be a	